Provider Insider

Alabama Medicaid Bulletin — **March 2003**

The checkwrite schedule is as follows:

03/07/03 03/21/03 04/11/03 04/25/03 05/09/03 05/23/03 06/06/03 06/20/03

As always, the release of direct deposits and checks depends on the availability of funds.

HIPAA Training Teleconferences Have Been Cancelled

The HIPAA Training Teleconferences for Providers have been cancelled. The scheduled teleconferences were designed to discuss with providers the upcoming changes with the PES software. Through contact with the provider community, EDS and the Medicaid Agency have determined the teleconferences will not best serve your needs. The new version of the PES software will be very similar to the current software, only slight changes will occur. When the new software is mailed, an updated User Guide with detailed instructions will be included.

To serve and educate you on the changes EDS and Medicaid will be making to comply with HIPAA regulations, we will be conducting training sessions in various locations throughout the state. The classes are tentatively scheduled for September. During these workshops, we will have a general billing session, discuss Medicaid billing changes related to HIPAA, and demonstrate the new PES software. More information on the workshops will be published in a future Provider Insider.

The HIPAA teleconferences for vendors have not been cancelled and will continue as scheduled. If you currently submit claims or eligibility transactions through a vendor, please contact your vendor to make sure they have enrolled in one of our teleconferences.

If you have any questions or require further assistance, please contact the Provider Assistance Center at 1-800-688-7989.

Medicaid Sets Date For Transition to HIPAA Format

September 26, 2003 will be the last day Medicaid claims can be submitted electronically to EDS in non-HIPAA compliant formats. All claims submitted electronically to EDS in non-HIPAA compliant formats after midnight of September 26, 2003 will be rejected at the point of submission, and must be resubmitted in a HIPAA compliant format.

It should be noted that electronic formats currently accepted by EDS, which include formats provided by EDS' PES software and all third party vendors, are non-HIPAA compliant. The only electronic format currently accepted by EDS that is HIPAA compliant is the NCPDP 5.1 Billing and Reversal transactions. EDS is currently upgrading the PES software for HIPAA compliance, as are most third party vendors. If you are using a third party vendor to submit your claims or a claims submission software developed by a third party vendor, you should contact your vendor concerning HIPAA compliance immediately.

All electronic claims submitted before the September 26, 2003 cutoff date will be processed for adjudication. During normal processing, a small percentage of electronic claims that have been submitted will set certain edits/audits and suspend for manual review. However during the September 26, 2003 claims processing cycle all electronic claims setting edits/audits will be denied. The denied claims will have a special Explanation of Benefit (EOB) code assigned, and can be resubmitted to EDS for processing in the appropriate HIPAA compliant format.

In This Issue…

Pass It On!

Everyone needs to know the latest about Medicaid.

Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Dept.*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other _____*

Dental Benefit Information Now Available

Providers are now able to access dental benefit information for any recipient when they call the Provider Assistance Center (PAC) at 1-800-688-7989 to verify the recipient's eligibility. This information is also available through the Medicaid software (PES) once you have upgraded with the latest version 1.11. If you have questions, please call the Dental Program at (334) 242-5472 or 353-5959.

Again, the codes that you will be able to see will be the last two PAID dates of service currently on the Medicaid system. The applicable codes will include:

Panoramic X-rays - D0330

Full Series X-rays - D0210

Oral Exams - D0120 or D0150

Prophylaxis/Fluoride - D1110, D1120, D1201, D1203, D1204, D1205

Space Maintainers - D1510, D1515, D1520, D1525, D1550

Medicaid Adds the MLIF Program

Effective April 1, Medicaid will transfer administration of the Medicaid for Low Income Families program (MLIF) from the Department of Human Resources to the Alabama Medicaid Agency. There are approximately 75,000 MLIF recipients in all. All SOBRA Outstationed workers will be handling these cases and are expected to begin taking new applications beginning April 1, 2003. DHR will stop taking new applications at the end of March, and will complete all pending work and provide a final file of all cases to Medicaid by the end of May 2003. MLIF will be added to the joint application currently being used for SOBRA Medicaid, All Kids, and the Alabama Child Caring Foundation. This transfer is a result of Welfare reform changes and recommendations from the Governor's Task Force on Children's Health Insurance. MLIF recipients will continue to receive the full Medicaid services they received in the past and there are no changes to the procedures for claims processing or eligibility verification for these individuals.

REMINDER

For recipients birth through 18 years of age, providers must utilize an appropriate CPT code on a HCFA-1500 claim form in order to receive reimbursement for the administration of each immunization given from VFC Stock for Medicaid children only. These administration fees may be billed in addition to an office visit or an EPSDT screening visit. Appendix A of the Provider Manual lists codes to utilize when billing the administration fee of VFC stock.

Medicaid Tidbits

Dental Reminders

Panoramic films (D0330) are limited to once per recipient every 3 years and cannot be billed in addition to a complete series (D0210).

Pulp Caps (D3110, D3120) are covered for permanent teeth only (excluding 3rd molars)

Core Buildups (D2950) are included with payment for cast or prefabricated post and cannot be billed separately.

Therapeutic drug by injection (D9610) is billable only by report and only when no definitive treatment is rendered on the same date of service.

Attention All Eye Care Providers

Please do NOT bill for lenses and/or frames furnished by another provider. Please be aware when filing claims that the claim reflects services actually rendered/provided. Billing for services not provided could be considered fraudulent. Please ensure your billing staff is aware of appropriate billing practices addressed in Chapter 15 of the Provider Manual.

CDT-4 Changes Coming

Please be on the look out for changes to procedure codes in the near future. There have been numerous changes through the ADA CDT-4 (Current Dental Terminology) in regards to deleted codes. Medicaid is currently working to review the codes deleted and make the appropriate changes. This will also mean changes to the fees paid on certain procedure codes. Medicaid will be sending out information in advance before these changes are implemented. The new codes and fees will not be effective until April 1,2003.

www.medicaid.state.al.us

Missed Appointments (No Call No Show)

Please be aware if a provider routinely accepts a Medicaid assignment, he or she may not bill Medicaid or the recipient for a service he or she did not provide, i.e., missed or canceled appointment.

The Alabama Medicaid Agency Referral Form

The correct procedure for completing the "Reason for Referral" block on the Agency's referral form is to indicate the appropriate diagnosis/reason/condition the recipient is being referred. The "Length of Referral" block must be completed to be considered a valid referral. Please ensure your office staff is aware of the procedures outlined above to prevent denials or unnecessary duplication of referral forms.

Unlisted Laparoscopic Procedures

When surgeons perform laparoscopic procedures on recipients for which a laparoscopic procedure code (PC) has not been established, they should bill the most descriptive PC with modifier 22 (unusual procedural services) until the new PC is established. Example: A surgeon performs a pyloromyotomy (cutting of pyloric muscle) laparoscopically. A procedure code for a laparoscopic surgery at this time has not been developed. Currently, the most descriptive procedure code for the procedure performed is PC 43520 although the description reflects a Fredet-Ramstedt type operation. When billing for this procedure, please bill PC 43520 with a modifier 22.

Medicaid Updating Medical Necessity

Medicaid is continuously evaluating and updating medical necessity for claim payment. Specifically, in an effort to ensure accurate coding and payment of claims, diagnosis / procedure code criteria are being added to the system. Any questions about denied claims for this reason should be directed to your EDS Provider representative.

New Survey Results from the Commonwealth Fund Report, September 2002

"A new survey of families with young Medicaid-insured children has found that while two of five parents have concerns about their infant or toddler's social, behavioral, or cognitive development, only about one of five said their child receives the full range of preventive and developmental services recommended by experts in pediatric care" according to the Commonwealth Fund report, Partnering with Parents to Promote the Healthy Development of Young Children Enrolled in Medicaid. "These findings confirm the need for continued efforts to bridge the gap between pediatric care guidelines and physician practice." The study was commissioned in three states (North Carolina, Vermont, and Washington) to obtain information on the status of health promotion and developmental services for Medicaid children. "Results show that while many parents and children receive some recommended preventive and developmental services, few receive the kind of comprehensive services that national guidelines and research literature suggest they need." To view the full report, please visit the Commonwealth Fund website at www.cmwf.org or you may order the report (publication number 570) by calling 1-888-777-2744.

DME Providers Must Verify Eligibility

DME providers must verify a recipient's eligibility prior to providing service to avoid risk of a denial of reimbursement for services provided. For this reason, it is important that every provider understands the terminology and processes associated with verifying recipient eligibility. Please refer to the Alabama Medicaid Provider Manual, Chapter 3, Verifying Recipient Eligibility. This chapter consists of three sections:

1. General Medicaid Eligibility, which describes who determines eligibility and identifies the valid types of recipient identification.
2. Confirming Eligibility, which describes the various methods for verifying eligibility. Please note that possession of a Recipient Identification (RID) card does not guarantee eligibility.
3. Understanding the Eligibility Response, which provides explanations for the various programs and limitations that define recipient eligibility. Providers should pay particular attention to this section, because there are several restrictions, limitations, and programs that may limit eligibility.

NOTE: Based on eligibility criteria, recipients may be eligible for full Medicaid benefits, or for certain services only. A recipient's age, health care requirements, and place of residence may further define his or her eligibility for Medicaid programs or services. Additionally, a recipient's history of Medicaid benefits may render him or her eligible or ineligible for specific programs or services. For these reasons, it is very important that providers verify recipient eligibility and ensure they understand all aspects of the eligibility response. Providers who do not verify eligibility prior to providing a service risk claim denial due to eligibility.

For Up-to-Date Medicaid Information Visit the Alabama Medicaid Website:

www.medicaid.state.al.us

Billing Information Concerning Prophylaxis and Fluoride Codes

On remittance for 02/21/03, there was a recoupment of all claims that contained incorrect processing of the prophylaxis and fluoride codes that were not the combined codes. Please note the following:

- All procedures codes that were on the claim that were billed correctly will be paid.
- The prophylaxis or fluoride code that was billed not using the combined code will suspend then deny on the next EOP.
- Once the procedures have denied, rebill using the correct combined code D1201 or D1205.
- When posting payment for services, you would only post the recoupment of the prophylaxis or fluoride. You have already been paid for the other services on previous EOPs.

If you have questions, please contact the Dental Program at (334) 242-5472 or 353-5959.

Visit Alabama Medicaid

ONLINE

www.medicaid.state.al.us

Providers can :

- **Print Forms and Enrollment Applications**
- **Download Helpful Software**
- **Receive Current Medicaid Press Releases and Bulletins**
- **Receive Billing and Provider Manuals and Other General Information about Medicaid**

HIPAA Information Concerning Trading Partner Agreements

All providers are required to fill-out and submit a Trading Partner Agreement (TPA). The TPA is a form used to gather specific information from providers to submit electronic information through our gateway. There are no signatures required on the form, only Company Information, Technical Contact Information, EDI Enveloping Information, and Transaction inform- ation (such as which transactions a provider desires to exchange with the State of Alabama).

If third party vendors or clearinghouses currently submit transactions on behalf of your organization they will need to complete a TPA. If you are a provider within a group, a TPA will need to be completed for each provider that submits transactions to Alabama Medicaid.

The TPA can be found by accessing the Alabama Medicaid website at www.medicaid.state.al.us/HIPAA/HIPAATPA.htm or by contacting the EDS Outreach and Documentation at (334) 215-4250 or hipaa@alxix.slg.eds.com.

NOTE: Website address is case sensitive

Medicaid Required to Submit Test Files Before HIPAA Implementation

All providers that submit transactions to Alabama Medicaid will be required to submit test files in the designated HIPAA format prior to implementation. If a third party vendor or clearinghouse currently submits transactions on behalf of your organization–that vendor will need to test.

Providers that utilize the Provider Electronic Solutions (PES) software, as provided by EDS, are exempt from testing.

Crossover Claims From Medicare Will Not Require an EMC Agreement

Claims which cross over from Medicare to Medicaid will not require an EMC agreement on file, these claims are identified with the ICN beginning with “10”. Claims that have denied for EOB code 220 will be reprocessed in the near future. Providers do not have to resubmit these claims. Providers who are submitting any other claims electronically must have a signed EMC agreement form on file with EDS. If you have any questions about this policy, please contact the Provider Assistance Center at 1-800-688-7989.

Alabama Medicaid

In The Know

Checklist for HIPAA Privacy

If you have determined you are required to comply with the privacy regulations under HIPAA, here is a checklist to help you with compliance.

- **Appoint a HIPAA privacy officer.**
- **Develop "minimum necessary" policies for:**
  - — Uses
  - — Routine disclosures
  - — Non-routine disclosures
  - — Limit request to minimum necessary
  - — Ability to rely on request for minimum necessary
- **Develop policies for access to designated record set:**
  - — Providing access
  - — Denying access
- **Develop policies for accounting of disclosures.**
- **Develop policies for amendment requests:**
  - — Accepting an amendment
  - — Denying an amendment
  - — Actions on notice of an amendment
  - — Documentation
- **Develop polices for business associate (BA) relationships and amend BA contracts or agreements:**
  - — Obtain satisfactory assurances in contract
  - — Document sanctions for non-compliance
- **Develop verification policies.**
- **Develop policies for alternative means of communication request.**
- **Develop policies for restricted use request.**
- **Develop complaint policies.**
- **Develop anti-retaliation policies.**
- **Develop appropriate administrative, technical and physical safeguards.**
- **Train workforce:**
  - — Train staff
  - — Develop sanctions for non-compliance.
- Develop and disseminate privacy notice.
- Limit disclosures to those that are authorized by the client, or that are required or allowed by the privacy regulations.

This checklist is to be used only to assist facilities in HIPAA awareness.
It is the responsibility of each facility to assess and comply with HIPAA as is appropriate.

The Alabama Medicaid Agency and EDS (Electronic Data Systems) are not responsible for providers becoming HIPAA compliant.

EDS Provider Representatives

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- Nurse Practitioners
- Podiatrists
- Chiropractors
- Independent Labs
- Free Standing Radiology
- CRNA
- EPSDT (Physicians)
- Dental
- Physicians
- Optometric (Optometrists and Opticians)

G R O U P 2

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- Rehabilitation Services
  - Home Bound Waiver
- Therapy Services (OT, PT, ST)
- Children's Specialty Clinics
- Prenatal Clinics
- Maternity Care
- Hearing Services
- Mental Health/Mental Retardation
  - MR/DD Waiver
- Public Health
  - Elderly and Disabled Waiver
  - Home and Community Based Services
  - EPSDT
  - Family Planning
  - Prenatal
  - Preventive Education
- Ambulance
- FQHC
- Nurse Midwives
- Rural Health Clinic
- Commission on Aging
- DME

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- Ambulatory Surgical Centers
- ESWL
- Home Health
- Hospice
- Hospital
- Nursing Home
- Personal Care Services
- PEC
- Private Duty Nursing
- Renal Dialysis Facilities
- Swing Bed

VFC Influenza Recommendations for the 2003-2004 Flu Season

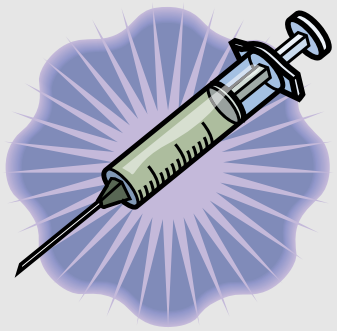
The recommendations include routine flu vaccination for children 6 months through 23 months and 2 years through 18 years who are household contacts of children aged less than two years. The VFC Program must order the next flu season's vaccine in April 2003. Therefore, VFC Providers should estimate their flu vaccine needs and place their order in March 2003 (1-800-469-4599 VFC Administration).

Immunization Information for Indian and Alaskan Natives

American Indian/Alaskan Native, uninsured, and under-insured children's immunization administration fee must be collected from the parent or guardian, not Medicaid. The administration fee must be waived if the parent or guardian cannot pay. Under-insured children can only receive VFC vaccine from a federally-qualified health center (FQHC) or a rural health center (RHC).

Clarification of Policy for Allergen Immunotherapy Multiple Injections

Consistent with CPT guidelines, professional services for allergen immunotherapy multiple injections (procedure codes 95117 and 95125) should be billed using only 1 unit. Effective April 1, 2003, Medicaid will deny claims for these procedure codes when more than 1 unit is billed.



Medicaid Urges Providers to Use Updated Enrollment Applications

To ensure we are providing the most up-to-date information, our enrollment applications are often being improved. For this reason, it is recommended that providers make certain they are completing and submitting the most recent version of the enrollment applications. Below is a list of the applications offered on our website and the date the application was last updated:

The Provider Enrollment Application for Providers in Alabama and Bordering States, January 2003; however, the July 2002 Version is acceptable until July 31, 2003

The Provider Enrollment Application for Out-of-State QMB/DME Providers, March 2001

The Provider Enrollment Application for Out-of-State Institutional Providers, March 2001

The Provider Enrollment Application for Out-of-State Practitioners January 2003: however, the September 2002 Version is acceptable until July 31, 2003

The Additional Location Enrollment Application, May 2002

Applications which are older than the dates listed above will no longer be accepted and will be returned to the submitting office or person. To obtain the most current version of an application or to verify you have the most recent version of the application, we encourage providers to visit our website at www.medicaid.state.al.us. On the home page, select the blue button labeled FORMS. On the following webpage, scroll down to the section labeled Provider Enrollment. Click on the enrollment application applicable to the enrolling provider.

By doing this, you can check the date of the packet applicable to the enrolling provider and print the application if necessary. If you do not have Internet access, you may call EDS' Provider Enrollment Department at 1-888-223-3630 or (334) 215-0111 to inquire about the applications.

NOTE: Any applications, which are not completed in black ink, will also be returned. Black ink is required due to the need to scan enrollment forms.

ATTENTION:

Physicians, ASCs and Hospitals

Unlisted procedure codes are not covered by Medicaid unless the provider requested prior authorization before the service was rendered. Medicaid will deny ALL requests for payment of unlisted codes after the fact.
(See page 3 for unlisted laparoscopic procedures)

Medicaid Provides Instructions for Third Party Billing

If you receive the full Medicaid allowed amount (less any recipient copay) for a service and also receive payment from a third party payer, you must do one of the following:

- Send an adjustment request to EDS. Medicaid should adjust the claim to reflect the third party payment; or
- Send a refund of the third party payment to Medicaid in an amount not to exceed the amount of the Medicaid payment. The refund should be mailed to the Third Party Division, Alabama Medicaid Agency, P O. Box 5624, Montgomery, AL 36103-5624.

Medicaid has identified numerous instances where the provider attached the insurance remittance to the Medicaid claim; however, the insurance payment was not in the appropriate field on the claim. As a result, the insurance payment was not deducted from the amount Medicaid paid the provider. This has resulted in numerous overpayments to providers. In addition, providers have received third party payments after Medicaid has made payment and these payments have not been reported to Medicaid.

Medicaid rules require that providers resolve overpayments due to third party payments within 60 days of the date the overpayment occurs. Therefore, providers should immediately resolve any such overpayments. Questions may be directed to Kay Keeshan or Keith Thompson at 334-5314.

Alabama Medicaid Bulletin

EDS

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